Testimony of
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For
"A Field Hearing on the Reauthorization of the Indian Healthcare Improvement Act"

Before
The Senate Indian Affairs Committee
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Crow Tribal Multi-Purpose Building, Crow Agency, Montana

Good afternoon, Chairman Dorgan and Senator Tester. My name is Jonathan Windy Boy. I am an enrolled member of the Chippewa Cree Tribe of Rocky Boy's Reservation and a citizen of the beautiful State of Montana. I have the honor to serve as a council member for the Chippewa Cree Tribe Business Committee. I also serve as a Representative in the Montana State Legislature, House District 32. I serve as the Chairman of the Rocky Boy Health Board, the governing body for the Chippewa Cree Health Center. I also serve as the chair of the Montana Wyoming Tribal Leaders Council - Subcommittee on Health and I was recently appointed the interim Chairman of the National Caucus of Native American State Legislators' – Subcommittee on Health. I appreciate this opportunity to address the healthcare issues of the Montana Tribes. I would like to thank the committee for the opportunity to testify at this "Field Hearing on Indian Healthcare".

Before I begin this testimony, I would like to reaffirm the foundation of the provision of health services in relationship to the sovereign status of Tribes.

"No right is more sacred to a nation, to a people, than the right to freely determine its social, economic, political and cultural future without external interference. The fullest expression of this right occurs when a nation freely governs itself."

The Late Joseph B. DeLaCruz
Former President
Quinault Nation, 1972 - 1993

The Foundation: Tribal Sovereignty and the Provision of Health Services

The overarching principle of Tribal sovereignty is that Tribes are and have always been sovereign nations, Tribes pre-existed the federal Union and draw our right from our original status as sovereigns before European arrival.

The provision of health services to Tribes is a direct result of treaties and executive orders entered into between the United States and Tribes. This federal trust responsibility forms the basis of providing health care to Tribal people. This relationship has been reaffirmed by numerous court decisions, Presidential proclamations, and Congressional laws.

The Situation Today: Underfunding of Indian Healthcare and American Indian/Alaska Native Health Disparities

Underfunding of Indian Healthcare

For some time now, the United States has not funded the true need of health services for AI/AN people. The medical inflationary rate over the past ten years has averaged 11 percent. The average increase for the Indian Health Service (IHS) health services accounts over this same period has been only 4 percent. This means that IHS/Tribal/Urban Indian (I/T/U) health programs are forced to absorb the mandatory costs of inflation, population growth, and pay cost increases by cutting health care services. There simply is no other way for the I/T/U to absorb these costs. The basis for calculating inflation used by government agencies is not consistent with that used by the private sector. OMB uses an increase ranging from 2–4 percent each year to compensate for inflation, when the medical inflationary rates range between 7-13 percent. This discrepancy has seriously

diminished the purchasing power of Tribal health programs because medical salaries, pharmaceuticals, medical equipment, and facilities maintenance cost Tribes the same as they do the private sector.

In FY 1984, the IHS health services account received $777 million. In FY 1993, the budget totaled $1.5 billion. Still, thirteen years later, in FY 2006 the budget for health services was $2.7 billion, when, to keep pace with inflation and population growth, this figure should be more than $7.2 billion. This short fall has compounded year after year resulting in a chronically under-funded health system that cannot meet the needs of its people.

As the federal government develops models that aim to reduce or eliminate racial and ethnic disparities (i.e. "Closing the Gap") a balance needs to be made between the federal deficit model (comparison to All U.S. Races) and a positive development model. Otherwise health policy (and the subsequent allocation of funding toward Indian healthcare) will be determined on the basis of Tribes being a marginalized minority and not as sovereign nations with distinct treaty rights, which have been negotiated with the *"**full faith and honor of the United States of America".***

American Indian/Alaska Native Health Disparities
American Indians have long experienced lower health status when compared with other Americans. Disproportionate poverty, discrimination in the delivery of health services and cultural differences has contributed to the lower life expectancy and disproportionate disease burden suffered by American Indians. American Indians born today have a life expectancy that s 2.4 years less than the US All Races.

American Indians die at higher rates than other Americans from:

- Tuberculosis – 600% higher
- Alcoholism – 510% higher
- Motor Vehicle Crashes – 229% higher
- Diabetes – 18% higher

- Unintentional injuries – 152% higher
- Homicide – 61% higher

Some of these health disparities are historic. Alcoholism continues to be a serious challenge to American Indian health. Since its introduction to Tribal people early in this Nation's history, alcohol has done more to destroy Indian individuals, families and Tribal communities than any disease. Today in 2007, Tribal people are dying at a rate 510% HIGHER than other Americans from alcoholism. The overall impact of these health disparities has made us "at-risk" communities, weakened and vulnerable. In fact, as reported in a Denver, Colorado newspaper, the Wind River Reservation in Wyoming was targeted by Mexican drug cartels because of their history with alcoholism. The drug dealers figured that the Tribal community (already inundated in alcohol addiction) would be easy to infiltrate for drug distribution. Their business plan included marrying into the Tribe, giving free samples to get people addicted and then get them to distribute to support their addiction. This is an approach that is being implemented throughout Indian Country.

Given the significant health disparities that Tribal people suffer, funding for Indian healthcare should be given the highest priority within the federal government. Many of the diseases that Tribal people suffer from are completely preventable and/or treatable with adequate resources and funding.

The Challenges: Access to Medicaid Services, Medicaid and Medicare Reimbursements, Recruitment and Retention of Health Providers

Access to Medicaid Services
The IHS budget cannot provide the health services needed thus Tribes must depend upon alternate health resources, such as, Medicaid for critically needed healthcare for our people. The Indian health system is funded at less than 60% of need and is heavily dependent upon Medicaid. Understanding this, accessing Medicaid is an important health issue.

The barriers to accessing Medicaid have been identified by Tribes through out the years. Though there has been some positive movement, many of those identified barriers still remain. The most critical of those identified is the application and eligibility determination process. This is the first gate and if a Tribal member cannot get through the first gate – access to needed healthcare is denied. The application and eligibility determination barriers are often protocols developed to "cost contain" or manage the National Medicaid budget. Unfortunately, Tribal people often cannot afford to jump through the "hoops" of a budget management protocol and the denial of access to care can be disastrous for the individual Tribal member and their family.

In FY 2004, the Chippewa Cree Tribe and the Confederated Salish & Kootenai Tribes partnered with the State of Montana and CMS/Region VIII to begin discussion on how to alleviate the barriers to accessing Medicaid for the Montana Tribes. In May 2007, the Chippewa Cree Tribe signed an agreement with the Governor of Montana and the State of Montana to contract Medicaid Eligibility Determination. Having the ability and authorization to determine Medicaid eligibility on site at our Tribal healthcare center will facilitate access to care for eligible Indian users that are eligible Medicaid users. Getting access to healthcare through Medicaid to those eligible Montana citizens (whether Indian or non-Indian) as soon as possible benefits the recipient and the State of Montana. A healthy state community is one where its citizens can fully participate in education, employment and economic development.

Medicaid and Medicare Reimbursement

Thirty one years ago, in 1976, in response to the health conditions in Indian Country, Congress provided the IHS and Tribes with the authority to bill for and receive Medicaid and Medicare reimbursements for services provided to American Indian beneficiaries. Today, Medicaid and Medicare reimbursements provide a critical source of supplemental funding for the underfunded IHS and Tribal healthcare delivery service programs.

Originally Congress did not intend for Medicaid revenue to "offset" the strained Indian Healthcare budget but to supplement it. Today, the IHS and Tribes are

expected to bill and collect for Medicaid to replace IHS appropriations. In the FY 2008 budget Request Congressional Justification includes specific amounts of Medicaid and Medicare collections (total of $625,193,000) as part of its total FY 2008 President's request of $4.1 billion. Members of the Committee, we need this situation remedied in order to realize an appropriate level of funding for Indian healthcare.

The Indian health system is funded at less than 60% of need and is heavily dependent upon Medicaid payments. States receive 100% FMAP for Medicaid services provided in an IHS or Tribal facility. These facilities have a limited capability to provide all needed direct care. Any health care not provided by the facility is referred to a private or public provider. The state must then provide the regular state Medicaid match for that eligible Indian user/eligible Medicaid user. Thus states are given an incentive to limit the benefits that American Indians referred to outside providers would receive under the state Medicaid plan.

A current issue relating to both Medicaid and Medicare is the imposition of increased cost sharing or premiums. States may charge a co-payment for medical services or drugs. The rationale for charging co-payments is to achieve a more appropriate utilization of Medicaid covered services. First of all American Indian participation is very low and the imposition of a co-pay has a negative effect as many American Indians cannot afford even a modest co-pay (and why would they if they can receive services from IHS without a co-pay). This could prevent them from enrolling in Medicaid or Medicare, which could deprive the chronically underfunded IHS or Tribal facility critical Medicaid revenue.

Imposing a co-payment has not changed the utilization of American Indian Medicaid or Medicare beneficiaries because IHS and Tribes do not charge co-pays to their beneficiaries. Instead co-pay amounts are cost shifted to the Indian health programs, causing a further reduction to services they can provide.

Recruitment and Retention of Health Providers

The recruitment and retention of health providers has been a barrier to effective healthcare delivery for Montana Tribes. As in most rural areas of this Nation, Montana Tribes are challenged with providing a continuity of care, because of a

high turnover of healthcare providers. Montana Tribes are located in geographically isolated areas (only Alaska has a remoteness designation more severe than Montana). Montana is considered a "frontier" area with a population of less than 6 people per square mile.

It is a challenge to recruit health providers that will commit to a long term, interact and invest in the Tribal Community and work to understand and respect the Tribal culture and traditions. These attributes for health providers are imperative to the effective provision of healthcare for our Tribal communities. Ideally, most Tribes want a Tribal member as their healthcare provider, knowing that a Tribal member would have the maximum investment for their community.

Chairman Dorgan and Senator Tester, it will take the commitment of the Administration, the U.S. Congress, the State of Montana, and the Montana Tribes to insure that the issues I have presented are addressed and accomplished by reauthorizing the Indian Healthcare Improvement Act. The provisions of the IHCIA will insure that Montana Tribes will have access to building the healthy Montana Tribal communities where healthcare is more than a promise but a reality for every man, women and child. I thank you for this opportunity to provide testimony.